age. Voiding cystourethrography of patients at 3 months showed no evidence of reflux. Furthermore, the patients did not have any further symptoms after 2 years of follow up.
Conclusions: Laparoscopic ureteral reimplantation in UVJO is a feasible and safe procedure. Symptoms disappeared postoperatively in both cases with considerable improvement. This can be offered a minimally invasive approach in management of UVJO with its advantage of better cosmetic result and short convalesce.

V-04.09
Laparoscopic partial nephrectomy in a transplanted kidney
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Introduction: The management of renal tumours (RT) in transplanted kidneys is the same as in native kidneys, provided that the graft's renal function proofs acceptable. The dissection tends to be more difficult due to inflammatory changes around the graft. The introduction of advanced laparoscopy means that even transplanted patients can benefit from a less invasive and oncological equivalent surgical technique.
Material and Methods: We present the case of a 56-year-old woman with a 3×4 cm RT on the posterior face of the graft, found 8 years after cadaveric kidney transplantation in the right iliac fossa. The patient was on immunosuppressive regimen with tacrolimus and corticosteroids. Patient accepted a laparoscopic partial nephrectomy with an elevated risk for conversion to open surgery. The patient is placed in a lateral lumbotomy position with dorsal inclination of 30°. Using a transperitoneal approach with 5 trocars and assisted by an AESOP 3000 robotic arm, a broad dissection of the right colon is performed. Then the graft's upper pole, the right native ureter and iliac arteries are dissected. Encountering only slight fibrosis, the limits of the RT are well defined and intraoperative ultrasound confirms no involvement of the urinary collecting system. After administering 20 mg of Manitol, the right external iliac artery is clamped, then proceeding with the partial nephrectomy. Incomplete renal ischemia due to retrograde arterial perfusion is confirmed by minimal bleeding during resection. A minimal perforation of the urinary tract occurred at the renal pelvis. Haemostasis is achieved with sutures, Floseal©, Surgicel© and Bioglue©. The RT is retrieved with an Endocath©-bag after leaving a suction drain.
Results: Operating time of 160 minutes with an estimated blood loss of 400cc and clamping time of 32 minutes. Besides a conservatively managed urinary fistula during the first 24 hours, the postoperative evolution was correct with discharge on day 6, showing a serum creatinine of 109 mg./dl. The pathology report showed a papilar renal carcinoma, pT1, with negative surgical margins.
Conclusion: Laparoscopic partial nephrectomy can be an alternative for treatment of renal graft tumours. Determinating factors in selection are tumour localisation, size and perirenal fibrosis.

V-04.10
Laparoscopic repair of iatrogenic long ureteral injury
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Introduction: Transection of the ureter in laparoscopic retroperitoneal lymph node dissection (RPLND) is a rare iatrogenic complication. Its repair is possible by end-to-end anastomosis when the defect is short, but if there is a long defect, laparoscopic repair is a challenge.
Methods: A 30-year-old man underwent modified RPLND of a clinically stage-A mixed germ cell of the left testis. While cutting the gonadal vein, 1.5 cm of the ureter was transected 2 cm below the renal pelvis and clipped by one of our residents. The injury was diagnosed immediately. After the completion of the modified RPLND, the clips were removed and a 20-mm defect of the ureter was seen precluding anastomosis. The kidney was dissected and pulled down 35 mm. The lower pole of the kidney was then fixed to the psoas muscle by a 2-0 vicryl, making anastomosis possible after an 8-mm spatulation of both sides. Anastomosis was done over a stent by interrupted sutures using 4-0 vicryl.
Results: Leakage was 400 mL at the first postoperative day and ceased at the 4th day. On the control excretion urography, the kidney function was normal and a fullness of the caliceal system was seen.
Conclusion: Long defect of the ureter that may occur in laparoscopic urological surgeries could be manageable laparoscopically using methods for shortening of the interval such as relocation of the kidney. Thus, a same approach as open surgeries can yield acceptable results in laparoscopic surgeries.

V-05: Infections & Inflammatory Diseases/ Sexual Function & Dysfunction/ Penis, Testis & Urethra
Tuesday, November 14
13:30-15:30

V-05.01
Laser vaporization in recurrent inflammatory urethral strictures
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Objective: Nowadays, recurrent urethral stricture (RUS) treatment still represents a problem for urological therapy. Our goal was to establish the value of Nd:YAG laser in these cases.
Methods: Between March 2002 and January 2006 in our clinical department 31 patients with RUS have been treated using the Nd:YAG laser. All cases had failed optical urethrotomy (1 or 2 recurrences). The length of the stricture was evaluated between 5 and 25 mm. In all cases we used laser contact vaporization. We used a Medilas fibertom 5060 type Nd:YAG laser (Dornier) with 1064 μm length wave. The urethrotomy was performed in 26 cases with the fiber indwelled through a cystoscope and in 5 cases through an ureteroscope. The Nd:YAG laser with the power set at 20 to 50 W was applied continuously in the contact mode using a 600 μm free-beam side-firing probe with a divergence of 17°. We continued the procedure by circumferential vaporization of the fibrous tissue until an adequate channel has been created and the healthy urethral tissue was clearly exposed. The urethral catheter was maintained between 1 and 4 days. All patients have been evaluated every 3 months, uroflowmetry being the main procedure. The mean follow-up period was 23 months (range 3 to 41 months).
Results: The success rate was 77.4% (24/31 cases). The main time for this procedure was 30 min. (20 to 45 min.). We had a complete and perfect visualization because of haemostatic laser quality. We didn't describe peri- and postoperative major complications. In 2 cases (6.4%), periurethral extravasation imposed percu-